

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

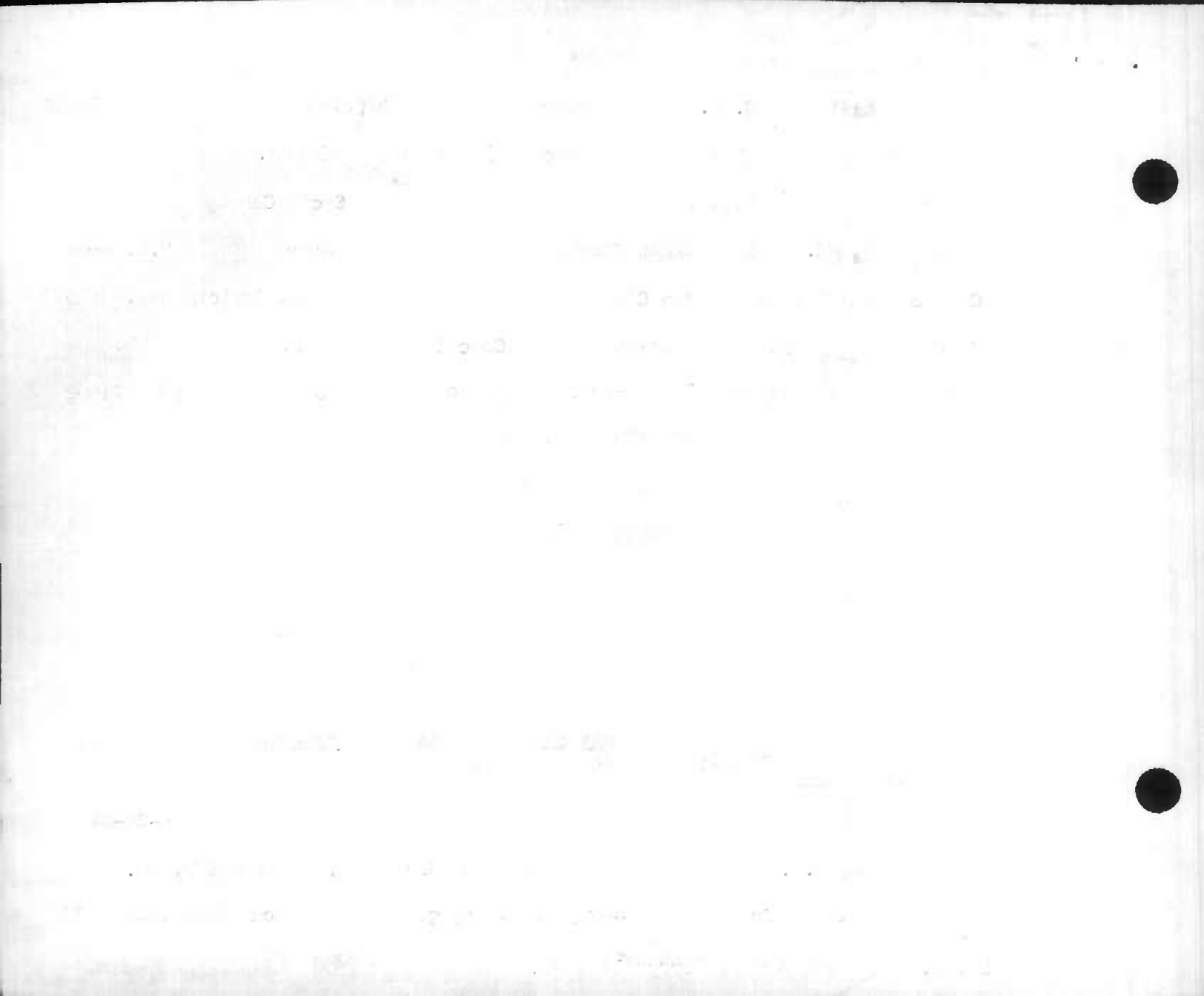
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

84 16527  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		HOUR MIN.	
MARY C. D. ALLEN		6/26/84		8:40P M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	MONTH DAY YEAR	83 yrs.	Cecil County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
New York	U.S.A.		Nurse		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE	
Perry Point, Md.	VA MEDICAL CENTER	U.S. Army		318 West Gaviota Ave. 92672	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
California	Orange	San Clemente	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	318 West Gaviota Ave. 92672	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	Yes 1941-1945			
Samuel E. Allen	Conchita A. D.	16b. SOCIAL SECURITY NO. 531-34-3955			
17. INFORMANT		ADDRESS			
V.A.M.C., Perry Point, Maryland		21902			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) RESPIRATORY FAILURE					
DUE TO, OR AS A CONSEQUENCE OF					
RIGHT CHEST PNEUMONIA					
DUE TO, OR AS A CONSEQUENCE OF					
ALZHEIMER'S					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MAY 22 1984, to JUNE 26 1984, that (we) lost the deceased alive on JUNE 26 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Prem Lal				6-26-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
PREM LAL, M.D.		VA MEDICAL CENTER, PERRY POINT, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		July 2, 1984		Arlington Nat'l Cem.	
23d. LOCATION		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
CITY OR TOWN COUNTY STATE		JUL 2 1984		John A. Patterson	
Arlington Arlington VA					
24. FUNERAL DIRECTOR (NAME AND ADDRESS)					
Lee A. Patterson & Son, Perryville, MD.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages headed "Cause of Death" should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Other," the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
8 4 1 6 5 2 8									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMMITT L. BLEVINS, SR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 13, 1984</b>			2b. HOUR <b>P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 14, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chrysler Corp.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>520 Blue Ball Road 21921</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Willie Edward Blevins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mimie - Cox</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>230-32-9138</b>		17. INFORMANT ADDRESS <b>Mrs. Martha Blevins, Elkton, Md. 21921</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocard infarction.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic vascular disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <b>6/13</b> 19 <b>84</b> to <b>6/13</b> 19 <b>84</b> that (1) we lost saw the deceased (2) we did not see the body after death. and that in (my) our opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE <b>Jui-Chih Hsu MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>6-15-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jui-Chih Hsu, M.D., M.A.</b>				22e. ADDRESS <b>223 W. Main St, Elkton, Md. 21921</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-18-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Blevins Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wise, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>HICKS HON. FOR FUNERALS</b>				ADDRESS <b>ELKTON, MD. 21921</b>		25a. DATE RECD. BY REGISTRAR <b>JUN 19 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

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[illegible]

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FOR Item 16b, film#G593 DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 4 1 6 5 2 9  
STATE REGISTRAR 7-18-84jlb CERTIFICATE OF DEATH REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS Edward CARTER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 16, 1984</b>		2b. HOUR <b>11:05 PM</b>	
3 SEX <b>Male</b>	4 RACE <b>Black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 3, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County MD</b>		
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center Perry Point, MD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Safety Analyst US Dept. of Transportation</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Virginia</b>	13b. COUNTY <b>Orange</b>	13c. CITY OR TOWN <b>Gordonsville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Post office Box 550 (22942)</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lincon Carter</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes/US Air Force/Rtd.</b>		16b. SOCIAL SECURITY NO. <b>230-03-5883</b>		17. INFORMANT <b>P.O. Box 550, Gordonsville, Pearl M. Locker Carter (wife) Virginia</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RIGHT OPTIC NERVE GLIOMA WITH INTERCEREBRAL METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Apr 26</b> , 19 <b>84</b> , to <b>June 16</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 16</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-16-84</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALEXIS ABRIL, M.D.</b>				22e. ADDRESS <b>VA Medical Center Perry Point, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>06/21/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arlington Co. Virginia</b>
24. FUNERAL DIRECTOR NAME <b>LATNEY FUNERAL HOME, Washington, D.C.</b>		25. DATE REC'D. BY REGISTRAR <b>JUN 29 1984</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

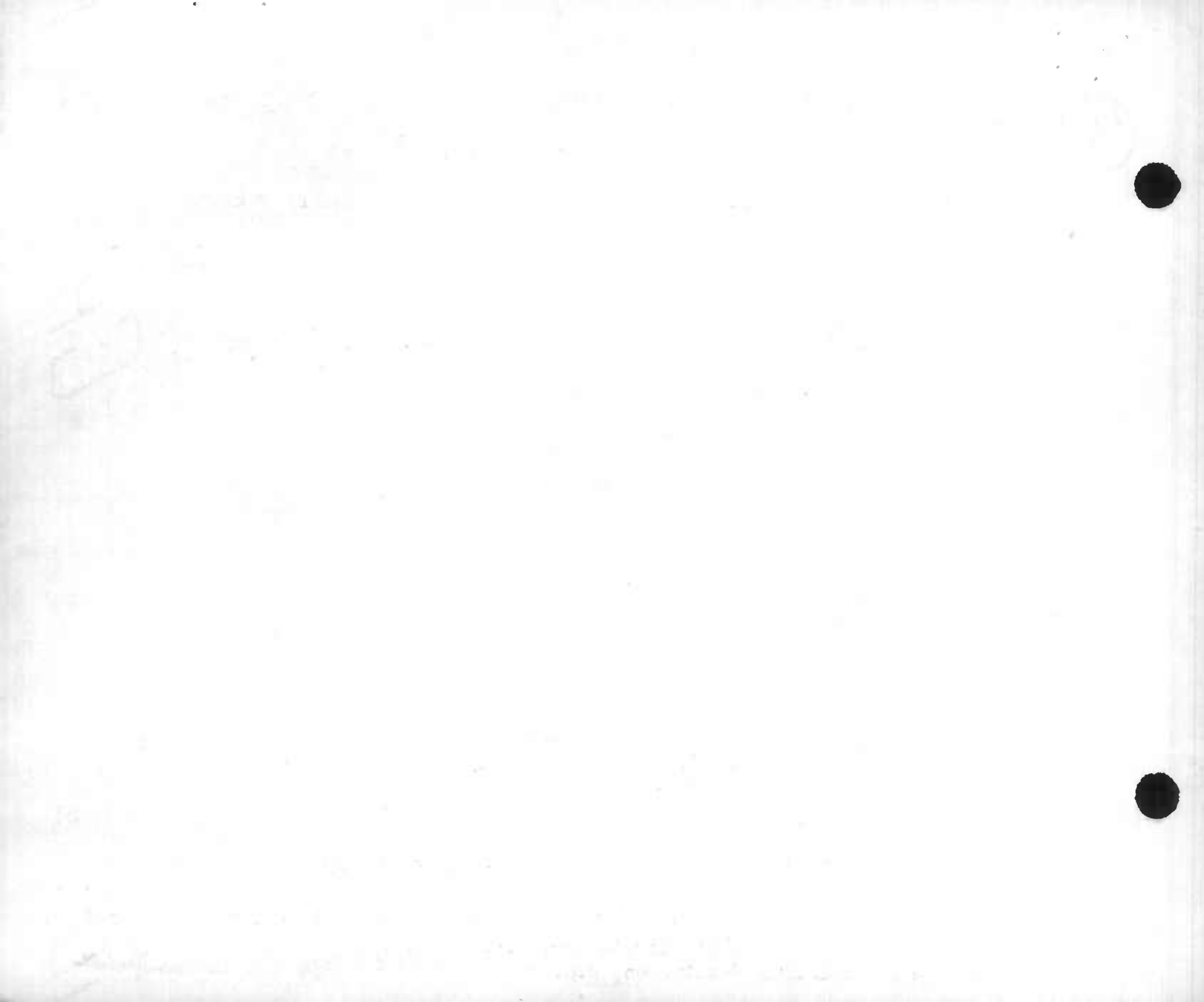
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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHW 16 50M 4/83  
(VRA 15, 4)



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 1 6 5 3 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE M. QUOMONY CLARK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 14 84</b>		2b. HOUR <b>1620 M.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT 4, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>ELKTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNION HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DOMESTIC</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. FAM.</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Perryville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>VALENTINE QUOMONY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HANNAH FLORENCE MILLER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>214-24-8800</b>		17. INFORMANT ADDRESS <b>JAMES W. CLARK, P.O. Box 272, Perryville, Md. 21903</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic obstructive lung disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1620 (M) 6 14 1984</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>1984</b> , to <b>June 14</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>June 14</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. P. Catlett MD</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-14-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 23, 1984</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Berkley Cemetery</b>		23d. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Springton, Harford, Md.</b>
24. FUNERAL DIRECTOR NAME <b>Otelia J. Bullock</b>		ADDRESS <b>Jane de Tracy, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>2-11-84</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	6			13	84	1800	M
Katherine G. Creeden		3. SEX		4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		Dec. 22 1887		96 yrs.		YRS		MONTHS	DAYS
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Pennsylvania		U.S.A.				Cecil Co		Housewife			
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
ELKTON		Union Hospital of Cecil County		Housewife				43 Fawn Lane		Levittown	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. CITY OR TOWN	
Pennsylvania		Bucks		Levittown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		43 Fawn Lane		Levittown	
4. FATHER'S NAME		5. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
James		Ella		No		160-01-5978B		Robert J. Creeden		43 Fawn Lane	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:		PART I DEATH WAS CAUSED BY:	
4293		4293		4293		4293		4293		4293	
IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)		IMMEDIATE CAUSE (a)	
Circum arrest		Circum arrest		Circum arrest		Circum arrest		Circum arrest		Circum arrest	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease		Arteriosclerotic Cardiovascular Disease	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:	
In other swallowing difficulty secondary to weakness		In other swallowing difficulty secondary to weakness		In other swallowing difficulty secondary to weakness		In other swallowing difficulty secondary to weakness		In other swallowing difficulty secondary to weakness		In other swallowing difficulty secondary to weakness	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		19d. AUTOPSY?		19e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		19f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		20d. AUTOPSY?		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		HOUR A.M. MONTH DAY YEAR				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION		21d. AUTOPSY?		21e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. AUTOPSY?		22e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		22f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Nov. 4, 1981, to June 12, 1984, that (I) (we) lost		S. RALPH ANDREWS MD		6-14-84		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
saw the deceased alive on June 4, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		22g. DATE SIGNED		22h. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		22i. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		S. RALPH ANDREWS MD		233 E. MAIN ST. ELKTON, MD 21921		6-14-84		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		23f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Burial		June 16, 1984		Holy Cross Cemetery		Yeadon Lansdowne Penn.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR		24. FUNERAL DIRECTOR	
Lee A. Patterson & Son, Perryville, Md.		Lee A. Patterson & Son, Perryville, Md.		Lee A. Patterson & Son, Perryville, Md.		Lee A. Patterson & Son, Perryville, Md.		Lee A. Patterson & Son, Perryville, Md.		Lee A. Patterson & Son, Perryville, Md.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE		25f. REGISTRAR'S SIGNATURE	
JUN 19 1984		JUN 19 1984		JUN 19 1984		JUN 19 1984		JUN 19 1984		JUN 19 1984	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MYRTLE E. HARMAN		MONTH DAY YEAR JUNE 7 84		21:24 M	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 3 9 13	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.		
10. CITY OR TOWN OF DEATH ELATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME
13a. STATE MD		13b. CITY OR TOWN CECIL	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 47 EDMONSON RD.	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN M. SLADE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET A. JOHNSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-30-6778		17. INFORMANT ADDRESS RISING R. RALPH HARMAN SUN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 4292 DUE TO, OR AS A CONSEQUENCE OF (b) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CHROMOCYSTOMA MS.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-24, 19-84, to 6-7, 19-84, that (I) (we) lost saw the deceased alive on 6-7, 19-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Blendo L. Lopez		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLANDO A. NATEJA		22e. ADDRESS 105 E MAIN ELATON MD			
23a. BURIAL, CREMATION, REMOVAL (BY) BURIAL		23b. DATE 6-11-84		23c. NAME OF CEMETERY OR CREMATORY EBENEZER	
23d. LOCATION CITY OR TOWN COUNTY STATE RISING SUN CECIL MD		23e. DATE REC'D. BY REGISTRAR			
23f. REGISTRAR'S SIGNATURE R.T. JORDAN FUNERAL HOME					

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1- FOR STATE REGISTRAR			3			4 16533	
1 DECEASED NAME (TYPE OR PRINT) M. Kent Hart			2a DATE OF DEATH MONTH DAY YEAR June 29, 1984			2b HOUR 10:20 M	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR June 24, 1913	6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canada	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
10 CITY OR TOWN OF DEATH Elkton	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b KIND OF BUSINESS OR INDUSTRY Ind.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13a STATE Md.	13b COUNTY Cecil	13c CITY OR TOWN North East	13e STREET ADDRESS 97 Bayside Dr. 21901				
14 FATHER'S NAME FIRST MIDDLE LAST Theodore Hart			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 468-07-7516		17 INFORMANT ADDRESS Marian Hart 97 Bayside Drive North East, Md. 21901			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD (Advance) Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCD. Osteoporosis of bone (spine) Recent fx of (Chip) old spine.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>6/27</u> 19 <u>84</u> to <u>6/29</u> 19 <u>84</u> , the (I/we) lost saw the deceased alive on above, (I/we) (did) (not) view the body after death. and that in my (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE Jui with Han MD			DEGREE MD			22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Jui Chih Han			22e ADDRESS 223 West main St. Elkton Md. 21921				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE 6-30-84		23c NAME OF CEMETERY OR CREMATORY Cratin & Ferris		23d LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa.	
24 FUNERAL DIRECTOR NAME Robert L. Brown				25a DATE REC'D. BY REGISTRAR JUL 03 1984			
25b REGISTRAR'S SIGNATURE Julia Davidson-Randall							

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Warner E. Henry</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>11</b> YEAR <b>84</b>		2b. HOUR <b>0600</b> M
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH MONTH <b>Jan.</b> DAY <b>17</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil C</b> MD.	
10. CITY OR TOWN OF DEATH <b>EIKTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Del.</b> 13b. COUNTY <b>NC</b> 13c. CITY OR TOWN <b>Middletown</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE <b>Henry</b> LAST <b>Henry</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Amanda</b> MIDDLE <b>Henry</b> LAST <b>Henry</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>222-07-2940</b>		17. INFORMANT <b>404 New Street Middletown, Del.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4920</b> IMMEDIATE CAUSE (a) <b>disruptive failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pulmonary emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>---</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Kenneth Lewis MD</b>		DEGREE		22c. DATE SIGNED <b>6/11/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kenneth Lewis MD</b>		22e. ADDRESS <b>Middle town, Del</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-6-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Chapel</b>	
24. FUNERAL DIRECTOR NAME <b>Haward C. Stevenson</b>		ADDRESS <b>403 Division St. Dover, Delaware</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>Davidson-Randall</b>		25c. REGISTRAR'S SIGNATURE			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				7. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Hazel Annette Hurd				7a. DATE OF DEATH MONTH DAY YEAR 06 02 84			
3. SEX female				7b. HOUR 2235 P.M.			
4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 04 05 1899		8. AGE (IN YEARS LAST BIRTHDAY) 85yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.	
10. CITY OR TOWN OF DEATH Elkton, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital of Cecil County		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife Ret.		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD				13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Cecil				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Vittum			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 003-12-4061		17. INFORMANT ADDRESS William A. Hurd (Son) Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) BRAINSTEM INFARCT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) HYPERTENSION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from JUNE 2-0, 19 84, to JUNE 2, 19 84, that (1) last saw the deceased alive on JUNE 2, 19 84, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gary A. Beste M.D.				DEGREE M.D.		22c. DATE SIGNED 6/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARY A. BESTE				22e. ADDRESS 131 W. MAIN ST. ELKTON MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-4-1984		23c. NAME OF CEMETERY OR CREMATORY Ebenzer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rising Sun, Cecil Co. Md.	
24. FUNERAL DIRECTOR NAME Richard L. Goodie				25. DATE RECEIVED BY REGISTRAR JUN 6 1984			

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JAN 10 1933  
U.S. DEPT. OF JUSTICE

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U.S. DEPT. OF JUSTICE



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JAN 10 1933  
U.S. DEPT. OF JUSTICE

Items #5 &amp; #6 G592 6/29/84

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

CW

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET E. HUSFELT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 9, 1984</b>		2b. HOUR <b>M</b>
3. SEX <b>F</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 2 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87 86</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.	
10. CITY OR TOWN OF DEATH <b>RISING SUN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CALVERT MANOR NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>DE</b>		13b. COUNTY <b>N.C.</b>	13c. CITY OR TOWN <b>Wilm</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1402 GREENHILL AVE</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEWIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CAROLYN CLARK</b>		16. ADDRESS <b>ALRIDGE HUSFELT - NEWARK DE</b>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		17b. SOCIAL SECURITY NO. <b>222-20-3362</b>		17c. INFORMANT <b>ALRIDGE HUSFELT - NEWARK DE</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>2900</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senile dementia</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>81</b> , to <b>6/9</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5/30</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James R. Dearworth, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/12/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Dearworth, M.D.</b>		22e. ADDRESS <b>167 W. Main St. Newark Del 19711</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-12-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SILVER BROOK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WILKINSON H.C. DE</b>
24. FUNERAL DIRECTOR NAME <b>Robert Howard</b> ADDRESS <b>RISING SUN</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 14 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the medical examiner must be notified by telephone.

#5, 46, Film G598 12/10/84 kam

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James R. Lucas</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>6</b> YEAR <b>84</b> 2b. HOUR <b>6:30 A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Aug</b> DAY <b>5</b> , YEAR <b>1918</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital/Elkton, Md</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cook</b>	
12b. KIND OF BUSINESS OR INDUSTRY -----		13a. STREET ADDRESS <b>211 East High Street</b>			
13b. STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles ---- Lucas, Jr</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-18-7709-A</b>		17. INFORMANT ADDRESS <b>Louise Lucas 211 E. High St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADVANCED PROSTATE CANCER</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Yogish A. Patel</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/6/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Yogish Patel</b>		22e. ADDRESS <b>Wilmington, Delaware</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/9/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Griffin Church</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cedar Hill MD</b>		24. FUNERAL DIRECTOR <b>Chris D. Congo</b>			
25a. DATE RECD. BY REGISTRAR <b>JUN 20 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>			

RECEIVED



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		KNOWN ESTIMATED		X MONTH		DAY		YEAR		2b. HOUR	
Robert Stanley McCall								6		25		19		84					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male	White	9-10-23		60 YRS.						6		25		19		84		4:19 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		U.S.A.		WIDOWED		DIVORCED		Cecil Co.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
North East		24 Beech Street		Plaster		Govt.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Cecil		North East		YES X NO		24 Beech St		21901									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Walter McCall		Edna Cameron																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		24 Beech St.													
Yes		WW II		221-12-0840		Judy N. McCall		North East, Md.		21901									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Small cell carcinoma of lung		DUE TO, OR AS A CONSEQUENCE OF											
								(b)		DUE TO, OR AS A CONSEQUENCE OF									
								(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO											
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2		WHILE AT WORK NOT WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE			
		P.M. 19																	
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion											
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner									
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
EXAMINER'S NAME		Union Hospital, Elkton, Md		21921															
(TYPE OR PRINT)																			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION													
Burial		6-28-84		North East Meth.		North East Cecil Md.													
24. FUNERAL DIRECTOR		NAME		DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE													
Rohat H. Curran				JUN 29 1984		Judy Davidson													



Robert M. Call

Black Hills - 1920

Black Hills - 1920

Black Hills - 1920

Black Hills - 1920

Black Hills - 1920

Black Hills - 1920

Black Hills - 1920

Black Hills - 1920



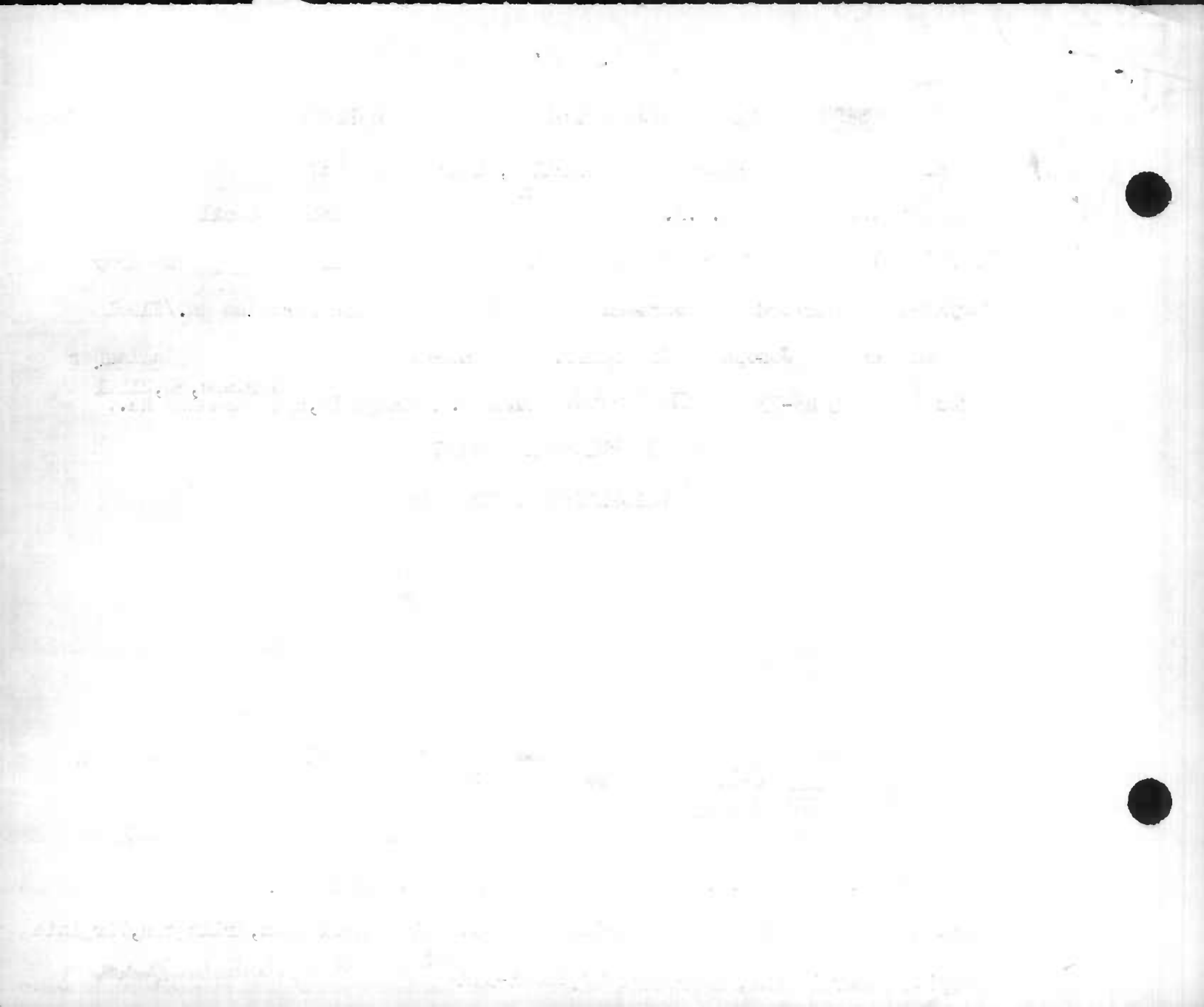
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without further delay with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner's findings should be noted on this page.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 1 6 5 3 9			
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH JOHN MCLAUGHLIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-12-84</b>			
3 SEX <b>Male</b>				2b. HOUR <b>4:05AM</b>			
4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 8, 1917</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MD</b>	
10 CITY OR TOWN OF DEATH <b>PERRY POINT</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VAMC, PERRY POINT, MD.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Harford</b> 13c. CITY OR TOWN <b>Aberdeen</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Joseph McLaughlin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Loretta Gallagher</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>45-73 215-38-7646</b>		17 INFORMANT <b>Anne M. McLaughlin</b> ADDRESS <b>Aberdeen, MD, 21001</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GLIOBLASTOMA, STAGE IV</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>6-9-84</b> , 19 <b>84</b> , to <b>6-12</b> , 19 <b>84</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6-12</b> , 19 <b>84</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Angel O. Vento, M.D.</b>				22c. DATE SIGNED <b>6-12-84</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANGEL O. VENTO, M.D.</b>	
22e. ADDRESS <b>VAMC, PERRY POINT, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>15 JUN 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arlington, Virginia</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Tarring Funeral Home, Aberdeen, Md. 21001-3399</b>				DATE REC'D. BY REGISTRAR <b>JUN 19 1984</b> REGISTRAR'S SIGNATURE <b>Graham Davidson-Randall</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 4 1 6 5 4 0			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>Frank Perugino, Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 19, 1984</b>		2b. HOUR <b>8:50P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 10, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>(RET) ASSEMBLY FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AUTOMOTIVE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>HAVRE de GRACE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN PERUGINO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY CIARLO</b>		13e. STREET ADDRESS / ZIP CODE <b>320 SOUTH UNION AVENUE 21078</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1943-45</b>		17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of urinary bladder with metastasis</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6-12-1984</b> to <b>6-19-1984</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>6-19-1984</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) not view the body after death.							
22b. SIGNATURE <b>Prem Lal</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-19-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PREM LAL, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>22 JUNE 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARFORD MEMORIAL GAROENS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ABEROEEN, HARFORD CO., MARYLAND</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell Funeral Home, P.A., Havre de Grace, Md.</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO.		8 4 1 6 5 4 1					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William W PRESTON				2a. DATE OF DEATH MONTH DAY YEAR 6 28 84		2b. HOUR 16:15 PM			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 30 1915		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Rail Road	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Walter R. Preston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilehemina Jones					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 188-07-4900		17. INFORMANT 728 Hances Pt. Rd. Idella Preston North East, Md, 21901					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) MULTIPLE MYELOMA DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph A. Patel MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-2-84		23c. NAME OF CEMETERY OR CREMATORY North East Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.			
24. FUNERAL DIRECTOR NAME Grouch Funeral Home				ADDRESS North East, Md		25. DATE RECEIVED BY REGISTRAR JUL 03 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

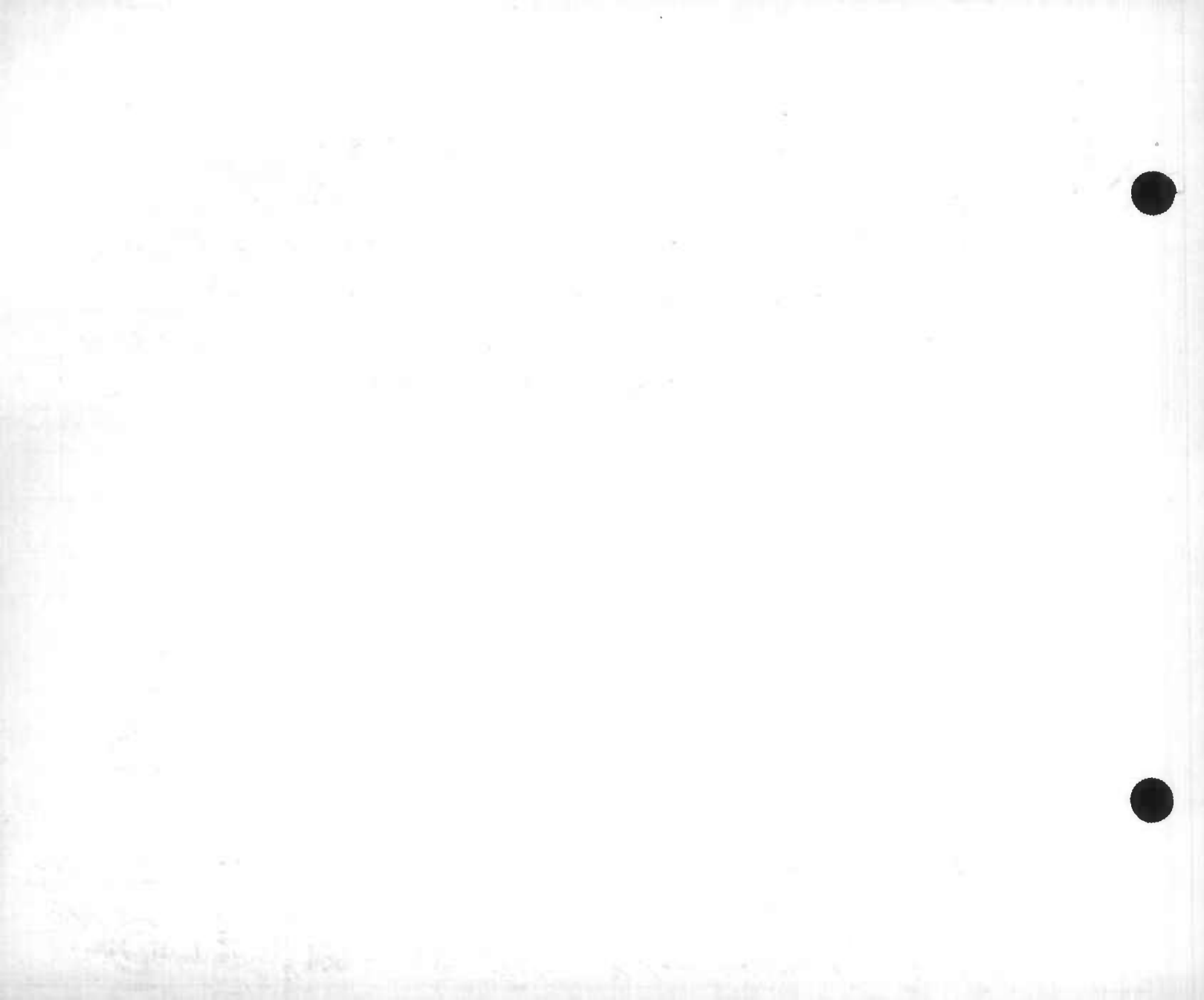
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8416542	
1- FOR STATE REGISTRAR					2a DATE OF DEATH		MONTH DAY YEAR		2b HOUR		
1 DECEASED NAME (TYPE OR PRINT) JAMES L. ROGERS					2a DATE OF DEATH 6-9-84		MONTH DAY YEAR		2b HOUR 1:00 A M		
3 SEX M		4 RACE W		5. DATE OF BIRTH 12 9 10		6. AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CECIL MD.					
10 CITY OR TOWN OF DEATH ELKTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NHCN				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b KIND OF BUSINESS OR INDUSTRY LABOR			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD					13b COUNTY CECIL		13c CITY OR TOWN RISING SUN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST OTTY D. ROGERS					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DORA LEE HENSEN						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 214-15-5231		17 INFORMANT ADDRESS JANE JONES NEWARK, DE							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED LUNG CANCER DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE Vogish A. Patel			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 6/10/84		
22d PHYSICIAN'S NAME (TYPE OR PRINT) VOGISH A. PATEL						22e ADDRESS NHCN HSP. ELKTON MD					
23a BURIAL, CREMATION, REMOVAL (CHECK) BURIAL			23b DATE 6-11-84		23c NAME OF CEMETERY OR CREMATORY FRIENDS		23d LOCATION CITY OR TOWN COUNTY STATE CALVERT CECIL MD				
24 FUNERAL DIRECTOR NAME R. T. FARD						ADDRESS RISING SUN MD		25a DATE REC'D. BY REGISTRAR JUN 14 1984		25b REGISTRAR'S SIGNATURE Julia Davidson-Romero	

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DHMM-16 20M  
(VRA 15, 4) 7/78





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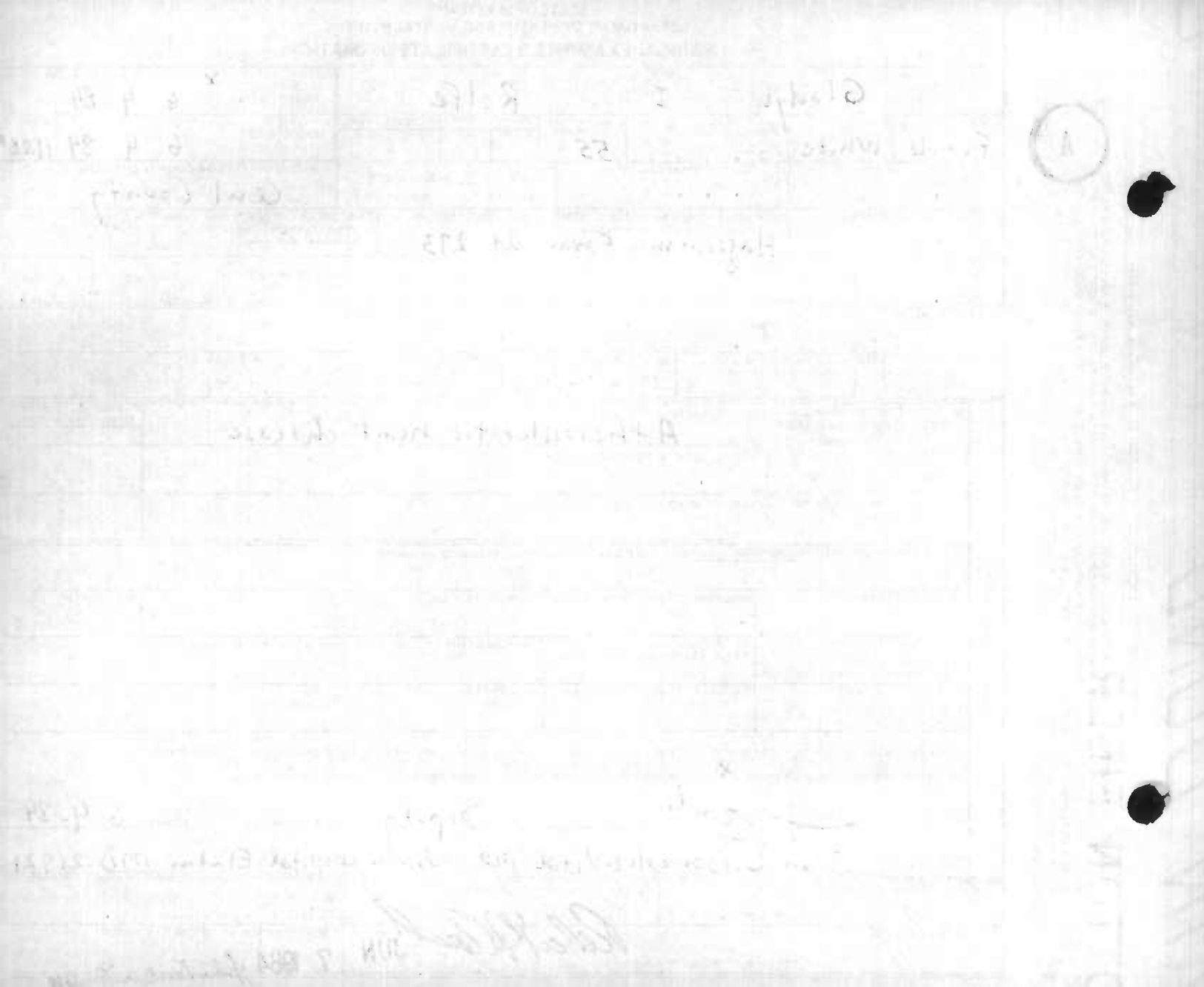
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 16543	
1. FOR STATE REGISTRAR						2. DATE KNOWN OF DEATH					
1. DECEASED NAME (TYPE OR PRINT) Gladys Irene Rolfe						2. DATE KNOWN OF DEATH ESTIMATED 6 4 1984					
3. SEX Female		4. RACE White		5. DATE OF BIRTH Feb. 16, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.				10. CITIZEN OF WHAT COUNTRY? U.S.A.				11. BALTIMORE CITY OR COUNTY OF DEATH Cecil County			
12. CITY OR TOWN OF DEATH Elkton				13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hagerman's Farm Rt 273				14. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING HOURS) Housewife			
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Md. 15b. COUNTY Cecil 15c. CITY OR TOWN Rising Sun				16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				17. STREET ADDRESS 217 Little New York Rd.			
18. FATHER'S NAME Frederick K. Williams						19. MOTHER'S MAIDEN NAME Susan Brown					
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						21. SOCIAL SECURITY NO. 213-30-7668					
22. INFORMANT Donald Rolfe						23. ADDRESS 217 Little New York Rising Sun, Md.					
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
25a. DATE OF OPERATION				25b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
27a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				28c. LOCATION STREET CITY OR TOWN COUNTY STATE			
29. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
30. ACTUAL SIGNATURE [Signature]						31. TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
32. EXAMINER'S NAME (TYPE OR PRINT) Juan C. Gonzalez-Vital						33. ADDRESS Union Hospital Elkton, MD 21921					
34. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				35. DATE 6-7-84				36. NAME OF CEMETERY OR CREMATORY Conowingo Baptist			
37. FUNERAL DIRECTOR NAME Crouch Funeral Home				38. ADDRESS North East, Md.				39. DATE BY REGISTRAR 7 1984			
40. REGISTRAR'S SIGNATURE [Signature]				41. REGISTRAR'S SIGNATURE [Signature]							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in its entirety by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 through 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 4 1 6 5 4 4	
1. FOR STATE REGISTRAR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
ADAM PAUL SIEMEK					June 9, 1984	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)
Male		White		11 15 10		73 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland		U.S.A.				Cecil County MD.
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Perry Point, Md.		VA Medical Center		Warehouseman		Shipping
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	
Maryland					Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. SOCIAL SECURITY NO.	
Henry			Siemek, Sr. Julia		214-01-2378	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			17b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes			214-01-2378		Henry J. Siemek, 6632 Hartwait Street Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY:						
2502 IMMEDIATE CAUSE (a) Second degree heart block and ventricular arrhythmia						
DUE TO, OR AS A CONSEQUENCE OF (b) Non ketogenic diabetic coma due to diabetes						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Cerebral arteriosclerosis						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
		P.M. 19				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (X) (this hospital) attended the deceased from July 12, 19 83, to June 9, 19 84. I saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE K. H. Huebner				DEGREE MD		22c. DATE SIGNED 6-11-84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. H. HUEBNER, M.D.				22e. ADDRESS VA Medical Center, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-13-84		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Baltimore Md.
24. FUNERAL DIRECTOR NAME ADDRESS Matthews Funeral Home, Baltimore, Md.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 12 1984 Julia		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 84 16545	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>JOAN P. SMITH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-7-84</b>		2b. HOUR <b>M</b>			
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>29 43</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>41</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CONN.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.					
10. CITY OR TOWN OF DEATH <b>ELKTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ELKTON</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>CECIL</b>		13c. CITY OR TOWN <b>RISING SUN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>359 CHANDLER DR. 21911</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>RAYMOND JOSEPH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOAN A. LEE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-46-8595</b>		17. INFORMANT ADDRESS <b>RISING SUN MD</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral artery Dissection anywhere</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD, DM</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>[Signature]</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-8-84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONINO H. CALON, MD, PA.</b>				22e. ADDRESS <b>611 S. UNION AVE, HARRE DE GRACE MD</b>							
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>BURIAL</b>		23b. DATE <b>6-9-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BROOKVIEW</b>		23d. LOCATION - CITY OR TOWN COUNTY STATE <b>RISING SUN CECIL MD</b>					
24. FUNERAL DIRECTOR'S NAME <b>R.T. FORD</b>		ADDRESS <b>FUNERAL HOME</b>		DATE REC'D. BY REGISTRAR <b>JUN 14 1984</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 9-9999.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 1 6 5 4 6 REG. NO.				
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME FIRST MIDDLE LAST MARGARETTA ANN HARTMAN SMITH				June 3, 1984				00:20
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR JULY 8, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.				
10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Pennsylvania		13b. COUNTY Delaware	13c. CITY OR TOWN Media	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 478 Darlington Road 19063		
14. FATHER'S NAME FIRST MIDDLE LAST Harry - Hartman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaretta - Cunningham						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 179-03-4632A		17. INFORMANT ADDRESS Mr. Melville H. Smith, Media, Pa. 19063				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) MASSIVE HEART ATTACK. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6-2, 19 84, to 6-3, 19 84, that (I) (we) last saw the deceased alive on 6-3, 19 84, and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Shasi Patel, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-3-84		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Shasi Patel, M.D.				22e. ADDRESS 62 N. Chapel Street, Newark, Del. 19711				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-7-84		23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bala Cynwyd, Mont. Pa.		
24. FUNERAL DIRECTOR NAME HICKS HOME FOR FUNERALS, ELKTON, MD. 21921				25a. DATE REC'D. BY REGISTRAR JUN 7 1984				
				25b. REGISTRAR'S SIGNATURE Julia Davidson				

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